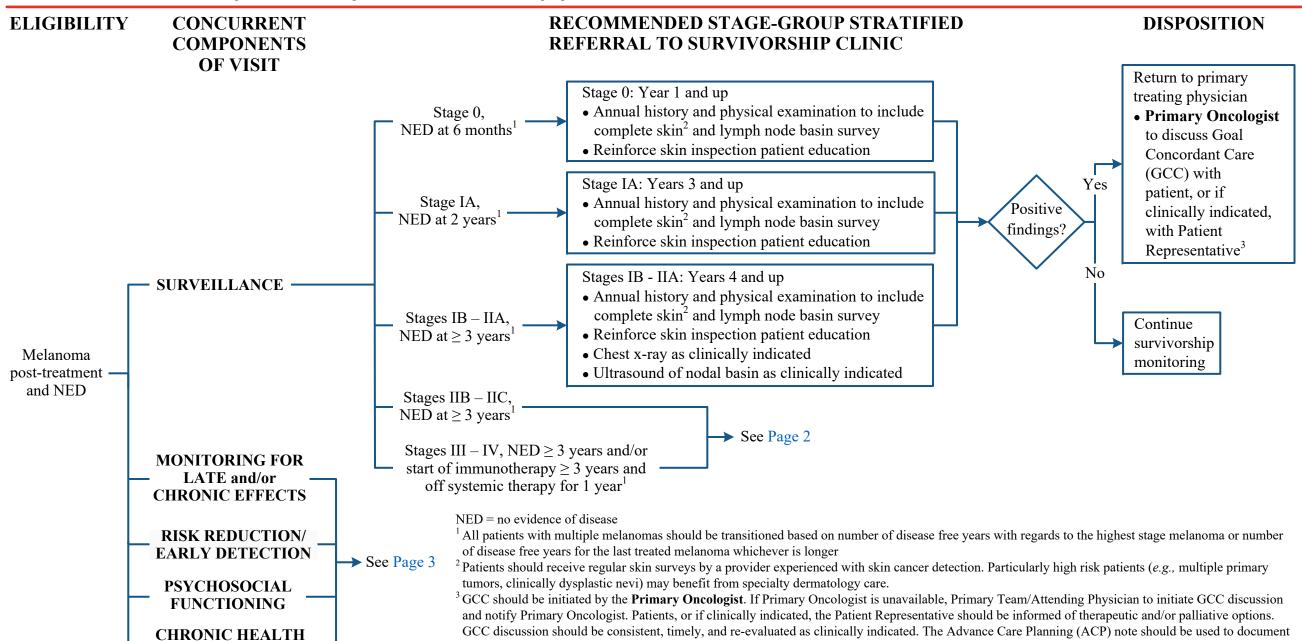


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GCC discussion. Refer to GCC home page (for internal use only).

MAINTENANCE

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ELIGIBILITY CONCURRENT COMPONENTS OF VISIT Stages IIB – IIC, NED at ≥ 3 years¹ Melanoma post-treatment — SURVEILLANCE and NED Stages III – IV, $NED \ge 3$ years and/or start of immunotherapy \geq 3 years and off systemic therapy ¹ All patients with multiple melanomas should be for 1 year¹ transitioned based on number of disease free years with regards to the highest stage melanoma or number of disease free years for the last treated melanoma whichever is longer ² Patients should receive regular skin surveys by a provider experienced with skin cancer detection. Particularly high risk patients (e.g., multiple primary tumors, clinically dysplastic nevi) may benefit from specialty dermatology care.

RECOMMENDED STAGE-GROUP STRATIFIED REFERRAL TO SURVIVORSHIP CLINIC

Stages IIB - IIC: Years 4 and 5

- Annual history and physical examination to include complete skin² and lymph node basin survey
- Reinforce skin inspection patient education
- CT chest, abdomen, and pelvis with contrast or PET-CT every 6 months or chest x-ray as clinically indicated
- MRI brain with contrast as clinically indicated

Stages IIB - IIC: Years 6 and up

- Annual history and physical examination to include complete skin² and lymph node basin survey
- Reinforce skin inspection patient education
- CT chest, abdomen, and pelvis with contrast or PET-CT or chest x-ray as clinically indicated
- MRI brain with contrast as clinically indicated

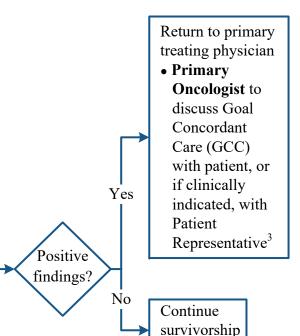
Stages III - IV: Years 4 and 5

- Annual history and physical examination to include complete skin² and lymph node basin survey
- Reinforce skin inspection patient education
- CT chest, abdomen, and pelvis with contrast or PET-CT every 6 months or chest x-ray as clinically indicated
- MRI brain with contrast as clinically indicated

Stages III - IV: Years 6 and up

- Annual history and physical examination to include complete skin² and lymph node basin survey
- Reinforce skin inspection patient education
- CT chest, abdomen, and pelvis with contrast or PET-CT or chest x-ray annually as clinically indicated
- MRI brain with contrast as clinically indicated

DISPOSITION



³GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

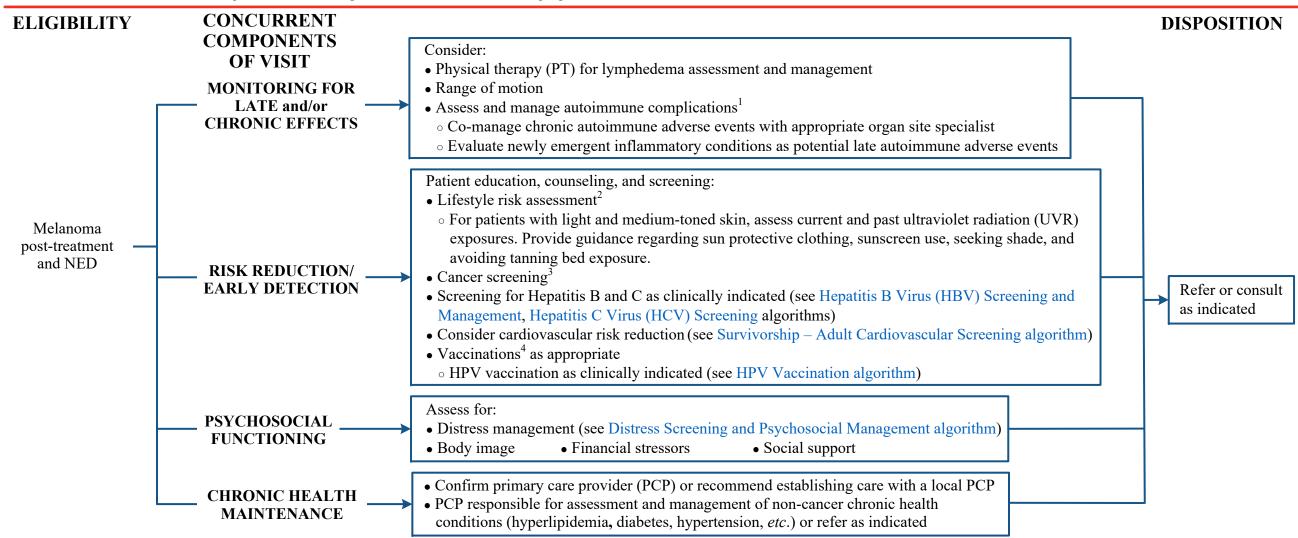
monitoring

Department of Clinical Effectiveness V6



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¹ Though most immune-related adverse events (irAEs) occur while on immunotherapy, some irAEs can manifest late and/or treatment-emergent irAEs may become chronic. Endocrine organ irAEs (i.e. hypothyroidism, adrenal insufficiency, Type 1 Diabetes Mellitus) are permanent and must be treated with life-long hormonal replacement with appropriate monitoring. Other irAEs, most commonly rheumatological or neurological, may be chronic or relapsing/remitting and require chronic immunosuppression. These chronic irAEs should be co-managed with appropriate organ site specialist. Thyroid function should be monitored annually in patients with immunotherapy exposure and the possibility of late irAEs considered for new inflammatory issues.

² See Physical Activity, Nutrition, Obesity Screening and Management, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

³ Includes breast, cervical, colorectal, liver, lung, pancreatic, prostate, and skin cancer screening

⁴Based on American Society of Clinical Oncology (ASCO) guidelines

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MD Anderson Survivorship — Cutaneous Melanoma

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This survivorship algorithm is based on majority expert opinion of the Melanoma Survivorship workgroup at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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